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Learning in and out of hospital

Editorial for April 2017 issue of *The Clinical Teacher*

Shortly after starting medical school I was rushed to hospital to have emergency surgery for testicular torsion. Some details are cloudy, but I remember the excruciating pain, and a disorientating blur of unfamiliar rooms, sounds, smells, equipment and people in uniforms doing things to me. My clearest pre-operative memory is of the anaesthetist describing in detail each layer she was crunching through with the spinal needle and the important structures to avoid. I was a medical student, so she thought I would want to know. I didn't remember the unsolicited anatomy lesson, but still remember the lovely, un-named nurse who held me and my hand as I cried with the pain. I also learned that slow and descriptive procedures are more terrifying and painful, before the welcome numbness and sedation kicked-in. I was wide awake and quite comfortable for the morning ward round - until the surgeon told me that I wouldn't mind being stripped naked whilst he explained the procedure to a dozen medical students, as I would understand how important it was for their learning. I wasn't really included in the discussion, but probably wouldn't have been able to say much anyway. I just wanted them to cover me up and leave. Later I wondered what, if anything, those students would have learned from that single encounter.

I think it is very helpful to reflect and learn from any experiences we have as patients, and from the experiences of those around us. We can also learn from the many patient stories in the literature, including clinicians and others writing about being patients, articles in the media, novels and movies, and collections such as 'Patient Voices' digital stories.¹ I suspect we can all think of clinical teaching situations which have been sub-optimal in patient-

centeredness and their potential for student learning. To be fair, when I went to hospital all I wanted was for a surgeon to fix me, stop the pain, and let me home again as soon as possible. Those expectations were met. Perhaps the other aspects would have been different had I been hospitalised with a more serious disease or exacerbation of a chronic condition. I certainly hope the experience would be different now, as there seems to be greater awareness of patient perspectives and the patient journey, the importance of continuity from a 'named' (designated) nurse and surgeon, of early analgesia, good communication, and informed consent for teaching and for clinical care. I think hospitals remain, however, unfamiliar, confusing, disempowering and generally quite scary places for the majority of patients. Most people with illnesses, both acute and chronic, are not in hospitals; and those who are may not be best placed to help with learning and teaching. Yet, paradoxically, hospitals are still where we find most clinical students and trainees.

Many articles in this issue explore alternatives to traditional clinical teaching with hospital inpatients. They describe the experiences of students interviewing older people in residential care homes,² attending mental health tribunals,³ working on widening participation in local schools,⁴ and following newly-diagnosed cancer patients from initial evaluation through all subsequent visits, consultations and procedures over the course of a year.⁵ They also describe sequential simulation training for pharmacists and other clinicians with an integrated approach to the patient journey between the community and hospital,⁶ and recommendations based on the experiences of students and a trainee who were learning in rural communities when natural disasters struck.⁷ The Toolbox paper explores how to maximise student and trainee learning in the ambulatory clinic (out-patient department),⁸ which might be thought of as somewhere between hospital and the

community. There is also an article reporting the perceived impact of teaching on the practice, enthusiasm and knowledge of clinical supervisors, and on the clinical environment and patient care, in non-teaching hospitals.⁹ This is consistent with previous studies which report benefits associated with teaching for clinicians, the health service, educational institution and patients.^{10, 11} There is recent evidence, however, that some teachers in the community, particularly physicians, are dissatisfied with the flow of patients through their clinics, working hours and income related to teaching.¹¹ These are important issues, as high-quality education should not be dependent on sustained teacher enthusiasm and goodwill alone. There also needs to be appropriate recompense in terms of funding, support, recognition, protected time and / or meaningful work.¹⁰

Some would argue that most clinical education takes place in hospitals because that is where the specialists are, such as the consultant-led medical, surgical and psychiatric teams, specialist nurses, rehabilitation teams and senior hospital pharmacists. I suspect in most cases there will also be significant administrative, practical, financial and politico-historical reasons for this – although in many countries there have recently been political drivers towards more community-based healthcare education. As a general practitioner ('GP' or family physician) I see different kinds of clinical specialisation and excellence in the community. The GP who initially visited my little room in student accommodation, correctly diagnosed my lower abdominal pain and called the emergency ambulance, attended alone. Arguably, he made the most difficult and consequential decision of my 'patient journey', yet no-one else learned from that opportunity. Diagnosing and managing acute illness in the community with limited equipment and support can be extremely difficult, even for experienced clinicians. Students and trainees in all disciplines must learn to look-out for

'red flag' symptoms and signs, and safely distinguish the serious and urgent from the everyday and minor. The physiotherapist or osteopath treating back pain thinks about cauda equina; the optometrist and dentist carefully assess any abnormal lesions; and the pharmacist asked for haemorrhoid cream thinks about more serious causes of rectal bleeding. We wouldn't expect students and junior trainees to assess and manage such patient presentations on their own, but as with more routine chronic disease management, there is much they can learn alongside an experienced clinician in these situations. We continually need to try and find our students and trainees the best possible learning opportunities, whether in hospital or the community. Then, as Worley and Couper remind us, the key is "Enabling the student to participate, in a meaningful way, in the clinician-patient interaction."¹⁰

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